JUST THE FACTS

DUAL DIAGNOSIS

AN EDUCATIONAL FACT SHEET FROM
THE FLORIDA ALCOHOL & DRUG ABUSE ASSOCIATION

Dual diagnosis refers to the presence of both a chemical dependency disorder and another serious psychiatric illness. The dually diagnosed client presents a challenge to the field of addiction treatment and especially to providers in inpatient and residential settings. Due to the severity of dysfunction, the dually diagnosed client adds stress to the treatment setting for both their peers and the treatment staff. Dually diagnosed clients can disrupt a treatment setting, polarize the staff and clients, be very demanding of attention and can raise the anxiety level of both clients and staff. The term dual is misleading. In most cases there are three diagnoses:

- Addictive disease
- A primary psychiatric diagnosis
- One or more underlying personality disorders or features

Typical mental disorders that are present in combination with addiction include:

- Psychosis such as schizophrenia and paranoid disorders, which are characterized by disturbances in thought and reality testing
- Affective Disorders, such as major depression, bipolar and dysthymic disorders, which are characterized by disturbances in mood
- Anxiety disorders, such as generalized anxiety disorders by some form of anxiety, and the phobic disorders in which anxiety is experienced when the client attempts to stop engaging in symptoms that function to avoid the anxiety

Of all the disorders mentioned above, addiction is most commonly found in combination with affective disorders.

Affective disorders refer to disorders of the personality or character structure that develop during childhood and typically become recognized in adolescence or early adulthood. These disorders represent conditions that are deeply entrenched and are characterized by maladaptive patterns of relating to self and others. These patterns of thinking, feeling and behaving create extreme difficulty in interpersonal relationships and functioning, as well as excessive amounts of emotional trauma.

The personality disorders have been grouped into three clusters. The first cluster includes paranoid, schizoid, and schizotypal personality disorders. Persons with those disorders often seem odd or eccentric. The second cluster includes borderline, narcissistic, antisocial and histrionic personality disorders. Persons with those disorders often seem dramatic, emotional or erratic. The third cluster includes aggressive personality disorder. Persons with those disorders often seem anxious or fearful.

These personality disorders are often not discrete clinical entities and may be found in combination or mixed with features of other personality disorders. Addiction may occur in combination with any one of these personality disorders, but appears to be most frequent in the borderline, narcissistic and antisocial personalities. Each of the three groupings of personality disorders is associated with its respective grouping of clinical syndromes (the grouped disorders of psychosis, affect disturbances and anxiety). These associated disorders will generally flow and ebb within the personality disordered client in response to periods of internally or externally generated stress and conflict. These clusters of associated disorders are ordered to a certain extent along a severity of disturbance index, so that disorders of thought generally represent higher levels of disturbance and impairment in functioning than mood disorders, while mood disorders have greater levels of disturbance relative to those disorders of anxiety. In general, the level of impairment has direct relationship to prognostic expectations.

ASSESSMENT AND IDENTIFICATION COME FIRST

Assessment and identification are the first steps for the treatment provider. When there is an indication of dual disorders, a consultation with a psychiatrist or psychologist is vital to establish the accurate diagnosis and assist in treatment planning.

Thorough initial assessment and history-taking are necessary and vital. Ongoing observation and assessment of the client and his interaction with others (staff and peers) in the treatment setting are invaluable in identifying dual disorders and in formulating treatment plan intervention. For example, disruptive, demanding or rule-breaking behaviors, particularly following initial detox, can

be indications of multiple disorders. The reactions of peers and staff can provide valuable information about the client's social functioning and his impact on others.

Safety for the client and others is one of the most serious assessment considerations. This becomes the top priority when there are indications of psychosis, suicidal or assaultive ideation. These indications should never be underestimated. While on some level these indications may represent a form of manipulation, they also point to serious pathology that can escalate or be acted on by the client suddenly. Appropriate interventions include treatment revision, close observation, consultation with a psychologist or psychiatrist, and possible referral to a more structured intensive setting for stabilization and/or treatment.

DIAGNOSIS AND TREATMENT

For any particular client, dual disorders have developed out of the same set of life experiences and physiological/psychological substrata. It follows that treatment and recovery issues for each disorder must be considered simultaneously. For example, symptoms of one disorder serve as all-too-effective relapse triggers for the other disorder and vice versa. The truism that these are not discrete problems with discrete solutions is certainly applicable.

When the decision is made to retain and treat a dually-diagnosed client, a number of clinical questions arise that challenge some of the traditional addiction treatment methods:

- Should psychotropic medications be administered?
- What happens when a client abuses a substance in treatment?
- What happens when a client won't attend a group or AA meeting?
- What aftercare issues arise?

BASIC PRINCIPLES

There are a few important principles that may be helpful in formulating a conceptual approach to the dual diagnosis challenge. These principles are rooted in the basic tenets of psychotherapy:

- Individualized Assessment. Therapeutic work must be based on individualized assessment and treatment of each client. This principle is critical given the wide variability in individual differences both between and within the dually-diagnosed client.
- Counselor Expectations. Counselors must develop realistic expectations of progress for each client while remembering that some will progress faster than others, that relapse is part of the recovery from any disorder, and that for both staff and client, maintaining strong expectations of hope is essential to the client's progress.
- Therapeutic Empathy. Treatment providers must continually broaden and apply the concept of therapeutic empathy so that they can relate the dually diagnosed client and gain a sense of how the client experiences his life and treatment. Providers must also be willing to develop and utilize their ability to protect the client to realize when the client is not able to tolerate a therapeutic intervention and to alter the treatment plan accordingly. This brings into question the applicability of traditional confrontational methods with the dually-diagnosed client.
- **Countertransference.** Providers must be aware of the heightened impact of countertransference in therapeutic relationships with clients, especially dually-diagnosed clients. Countertransference comes into play when any of the provider's codependent behaviors are triggered by the behavior of the dually diagnosed client.

CONCLUSION

Assessment of chemical dependency requires a thorough history of clients' substance use and related problems. Since the effects of substances can mimic virtually any psychiatric symptom, it is often necessary for the client to be drug-free for two to six weeks or more before the clinician can accurately establish any coexisting psychiatric diagnoses. Because dual disorders are complex problems, chemical dependency clinicians may need to seek consultation with psychiatric experts, and mental health clinicians may need advice from chemical dependency experts.

Florida's Choice
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